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Amendment No. 3 to HB4011

Hargrove
Signature of Sponsor

AMEND Senate Bill No. 3895* House Bill No. 4011

by deleting all language after the enacting clause and substituting instead the following:

SECTION 1. Tennessee Code Annotated, Title 4, Chapter 40, is amended by adding the following as a new part 4:

4-40-401. This part shall be known and may be cited as the "Diabetes Prevention and Health Improvement Act of 2006".

4-40-402. As used in this part, unless the context requires otherwise:

(1) "Board" means the governing body of the Tennessee Center for Diabetes Prevention and Health Improvement.

(2) "Center" means the Tennessee Center for Diabetes Prevention and Health Improvement.

(3) "Non-profit organization" means an entity that is exempt from federal income taxation under § 501(a) of the Internal Revenue Code as an organization described in § 501(c)(3) of the Internal Revenue Code.

4-40-403.

(a) The Tennessee Center for Diabetes Prevention and Health Improvement is hereby established. The Center shall be attached to the Department of Finance and Administration for administrative purposes, but shall be independent of the department.

(b) The purpose of the Center is to develop, implement and promote a statewide effort to combat the proliferation of Type 2 diabetes.

(c) The duties of the Center shall include the following:

(1) Developing, implementing and promoting programs to encourage and support healthy lifestyle choices by the citizens of this state;

(2) Providing informational resources and technical assistance to schools, business entities, non-profit organizations, agencies of state government, and political subdivisions of the state that are seeking information on best practices in the areas of Type 2 diabetes, obesity and healthy lifestyle choices;

(3) Conducting research and pilot projects with the objective of developing and disseminating best practices in the prevention and management of diabetes;

(4) Making policy recommendations to local, state and federal governmental entities related to controlling the proliferation of Type 2 diabetes and promoting healthy lifestyles in Tennessee; and

(5) Taking other necessary action to control the proliferation of Type 2 diabetes and encourage the adoption of healthy lifestyle choices by state citizens.

4-40-404.

(a) The Center shall operate under the direction of an eleven (11) member board of trustees who shall be appointed by the governor.

(b) The membership of the board shall appropriately reflect the racial and geographic diversity of this state.

(c) In addition to the eleven trustees appointed by the governor, the commissioner of health, the commissioner of education and the commissioner of agriculture, or their designees, shall serve as ex-officio, non-voting members of the board.

(d) The Governor shall appoint a chairperson from the membership of the Board, who shall serve a two (2) year, renewable term as chairperson.

(e) Trustees shall serve four (4) year, renewable terms; provided that of the initial trustees appointed:

(1) Three (3) trustees shall be appointed for an initial term of four (4) years;

(2) Three (3) trustees shall be appointed for an initial term of three (3) years;

(3) Three (3) trustees shall be appointed for an initial term of two (2) years; and

(4) Two (2) trustees shall be appointed for an initial term of one (1) year.

(f) Should a board position become vacant through resignation, removal, or other cause, the governor shall appoint a new member to serve the unexpired term. Trustees shall continue to serve on the board after the expiration of their term until a new trustee is appointed.

(g) A quorum of the board shall be seven (7) trustees.

(h) Trustees shall receive no compensation for their service on the board, but may be reimbursed for those expenses allowed by the provisions of the comprehensive travel regulations as promulgated by the Department of Finance and Administration and approved by the Attorney General and Reporter.

(i) The board shall adopt and implement a policy related to conflicts of interest to ensure that all trustees avoid any situation that creates an actual or perceived conflict of interest related to the work of the trust fund.

(j) The board shall submit an annual report to the governor, speaker of the house and speaker of the senate by June 30 of each year. Such report shall include detailed information on the operation and financial status of the Center.

4-40-405.

(a) Moneys appropriated to the Center shall be invested by the state treasurer in accordance with applicable general law, except as qualified by this part. Such monies shall be held separate and apart from all other moneys, funds, and accounts in a special agency account within the state general fund.

(b) Any balance remaining unexpended at the end of a fiscal year in such account shall be carried forward into the subsequent fiscal year.

(c) Investment earnings credited to the assets of such account, including but not limited to interest, shall be carried forward into the subsequent fiscal year.

(d) The Center is authorized to request and receive gifts, contributions, bequests, donations and grants from any legal and appropriate source to effectuate its purpose. Any such funds received shall be deposited into the special agency account created pursuant to subsection (a).

(e) Moneys in the special agency account shall be expended only in accordance with, and for the purposes stated in, the provisions of this part. No part of this account shall be diverted to the general fund or any other public fund for any purpose whatsoever.

4-40-406. The Center is authorized to create or establish a non-profit organization which shall also be eligible to request and receive gifts, contributions, bequests, donations and grants from any legal and appropriate source to effectuate the Center's purpose.

4-40-407. The Center is authorized to promulgate any rules necessary to carry out the proper administration of this part. Such rules shall be promulgated in accordance with the provisions of the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

SECTION 2. The Tennessee Center for Diabetes and Health Improvement Board of Trustees, created by SECTION 1 of this Act, shall terminate on June 30, 2008.

SECTION 3. Tennessee Code Annotated, Title 56, Chapter 7, is amended by adding the following as a new part 29:

56-7-2901. This part shall be known and may be cited as the "Access Tennessee Act of 2006."

56-7-2902. It is the intent of the general assembly to provide access to health insurance coverage to Tennesseans who are unable to qualify for adequate health insurance. By the language of this Act, it is specifically the intent of the general assembly to establish a mechanism that offers adequate levels of health insurance coverage to residents of Tennessee who are otherwise uninsurable or who are underinsured.

56-7-2903. As used in this part, unless the context otherwise requires:

(1) "Access Tennessee" means the nonprofit entity created pursuant to § 56-7-2904(a);

(2) “Board” means the Access Tennessee board of directors established pursuant to § 56-7-2904(b);

(3) “Church plan” has the meaning given such term under ERISA (29 U.S.C. § 1002(33));

(4) “COBRA continuation coverage” refers to continuation of coverage offered pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. §§ 300bb-1 *et seq.*);

(5) “Commissioner” means the commissioner of finance and administration;

(6) “Creditable coverage” means:

(A) With respect to an individual, coverage of the individual provided under any of the following:

(i) A group health plan;

(ii) Health insurance coverage;

(iii) Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. §§ 1395 *et seq.*);

(iv) Medicaid, other than coverage consisting solely of benefits under § 1928 of the Social Security Act (42 U.S.C. § 1396s);

(v) The Civilian Health and Medical Program of the Uniformed Services (10 U.S.C. §1071 *et seq.*);

(vi) A medical care program of the Indian Health Service or of a tribal organization;

(vii) A state health benefits risk pool;

(viii) A health plan offered under the Federal Employees Health Benefits Program (5 U.S.C. §§ 8901 *et seq.*)

(ix) A public health plan as defined in federal regulations; or

(x) A health benefit plan under the Peace Corps Act (22 U.S.C. § 2504(e)).

(B) A period of creditable coverage shall not be counted, with respect to the enrollment of an individual who seeks coverage under this part, if, after such period and before the enrollment date, the individual experiences a significant break in coverage;

(7) "Department" means the department of finance and administration;

(8) "Dependent" means a spouse or unmarried child under the age of nineteen (19) years, or a child who is a student under the age of twenty-three (23) years and who is financially dependent upon the parent;

(9) "ERISA" means the Employee Retirement Income Security Act of 1974 (29 U.S.C. §§ 1001 *et seq.*);

(10) "Federally defined eligible individual" means an individual:

(A) For whom, as of the date on which the individual seeks coverage under this part, the aggregate of the periods of creditable coverage, as defined in subsection (6), is eighteen (18) or more months;

(B) Whose most recent prior creditable coverage was under a group health plan, governmental plan, church plan or health insurance coverage offered in connection with such a plan*;*

(C) Who is not eligible for coverage under a group health plan, Medicare, Medicaid, or any successor program, and who does not have other health insurance coverage;

(D) With respect to whom the most recent coverage within the period of aggregate creditable coverage was not terminated based on a factor relating to nonpayment of premiums or fraud;

(E) Who, if offered the option of continuation of coverage under a COBRA continuation coverage provision or under a similar state program, elected such coverage; and

(F) Who has exhausted the continuation coverage described in subdivision (E);

(11) “Fund” means the Access Tennessee Health Insurance Pool fund established by § 56-7-2911(e);

(12) “Governmental plan” has the meaning given such term under ERISA (29 U.S.C. § 1002(32));

(13) “Group health plan” means an employee welfare benefit plan as defined in ERISA (29 U.S.C. § 1002(1)) to the extent that the plan provides medical care, as defined in subsection (20), and including items and services paid for as medical care to employees or their dependents as defined under the terms of the plan directly or through insurance, reimbursement or otherwise;

(14) “Health insurance coverage” means:

(A) Any hospital and medical expense incurred policy, nonprofit health care service plan contract, health maintenance organization subscriber contract, or any other health care plan or arrangement that pays for or furnishes medical or health care services whether by insurance or otherwise.

(B) “Health insurance coverage” shall not include one or more, or any combination of, the following:

(i) Coverage only for accident, or disability income insurance, or any combination thereof;

(ii) Coverage issued as a supplement to liability insurance;

(iii) Liability insurance, including general liability insurance and automobile liability insurance;

(iv) Workers’ compensation or similar insurance;

(v) Automobile medical payment insurance;

(vi) Credit-only insurance;

(vii) Coverage for on-site medical clinics; and

(viii) Other similar insurance coverage, specified in federal regulations issued pursuant to the Health Insurance

Portability and Accountability Act of 1996 (42 U.S.C. §§ 201 *et seq*.), under which benefits for medical care are secondary or incidental to other insurance benefits.

(C) "Health insurance coverage" shall not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the coverage:

(i) Limited scope dental or vision benefits;

(ii) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(iii) Other similar, limited benefits specified in federal regulations issued pursuant to the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. §§ 201 *et seq*.).

(D) "Health insurance coverage" shall not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(i) Coverage only for a specified disease or illness; or

(ii) Hospital indemnity or other fixed indemnity insurance.

(E) "Health insurance coverage" shall not include the following if offered as a separate policy, certificate or contract of insurance:

(i) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act (42 U.S.C. § 1395ss(g)(1));

(ii) Coverage supplemental to the coverage provided under Civilian Health and Medical Program of the Uniformed Services (10 U.S.C. §1071 *et seq.*); or

(iii) Similar supplemental coverage provided to coverage under a group health plan;

(15) "Health maintenance organization" means an organization as defined in § 56-32-202;

(16) "Hospital" means a licensed public or private institution as defined by § 68-11-201;

(17) "Insurance arrangement" means, to the extent permitted by ERISA, any plan, program, contract or other arrangement under which one or more employers, unions or other organizations provide to their employees or members, either directly or indirectly through a trust or third party administration, health care services or benefits other than through an insurer;

(18) "Insurer" means any entity that provides health insurance coverage in this state. For the purposes of this part, insurer includes but is not limited to an insurance company; a health maintenance organization; a preferred provider organization, a hospital and medical service corporation; a surplus lines insurer; an insurer providing stop-loss or excess loss insurance to a group health plan; a reinsurer reinsuring health insurance in this state, and any other entity providing a plan of health insurance or health benefits subject to state insurance regulation;

(19) "Medicaid" means the federal- and state-financed, state-run program of medical assistance established pursuant to Title XIX of the Social Security Act (42 U.S.C. §§ 1396 *et seq.*) and any waivers thereof;

(20) "Medical care" means amounts paid for:

(A) The diagnosis, care, mitigation, treatment, or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body;

(B) Transportation primarily for and essential to medical care referred to in subdivision (20)(A); and

(C) Insurance covering medical care referred to in subdivisions (20)(A) and (B);

(21) "Medicare" means coverage under Parts A and/or B of Title XVIII of the Social Security Act, (42 U.S.C. §§ 1395 *et seq.*, as amended);

(22) "Plan of operation" means the articles, bylaws, and operating rules and procedures adopted by the board pursuant to § 56-7-2904(i);

(23) "Pool" means the Access Tennessee Health Insurance Pool created in § 56-7-2904(a);

(24) "Preferred provider organization" means any person, partnership, association, corporation or entity which contracts with a hospital, hospitals and/or other health care providers for the provision of health care services by the hospital, hospitals and/or health care providers at a discounted rate, a per diem charge or any other pricing arrangement which is less than the charge made for medical services without such a contract arrangement;

(25) "Resident" means an individual who is legally domiciled in Tennessee;

(26) "Significant break in coverage" means a period of sixty-three (63) consecutive days during all of which the individual does not have any creditable coverage, except that neither a waiting period nor an affiliation period is taken into account in determining a significant break in coverage;

(27) "Third party administrator" means any entity that, on behalf of an insurer or insurance arrangement, provides health insurance coverage to individuals in this state, receives or collects charges, contributions or premiums for or adjudicates,

processes or settles claims in connection with any type of health benefit provided in or as an alternative to health insurance coverage; and

(28) "Unfair referral" means a referral to the pool described in § 56-7-2908(g).

56-7-2904.

(a) There is hereby created a nonprofit entity known as Access Tennessee to operate an insurance pool to provide health insurance coverage pursuant to the provisions of this part. The pool shall be known as the Access Tennessee Health Insurance Pool.

(b) Access Tennessee shall operate the pool subject to the supervision and control of a board of directors composed of eleven (11) members. The commissioner shall, within ninety (90) days after July 1, 2006, give notice to all insurers of the time and place for the initial organizational meetings of the board. The board shall consist of the following members:

(1) The commissioner of finance and administration or his or her designee;

(2) The commissioner of health or his or her designee;

(3) The commissioner of mental health and developmental disabilities or his or her designee;

(4) One (1) representative of a medical hospital service association plan selected by the commissioner (unless, pursuant to subsection (d), no such representative is able to serve, in which case this position shall be filled by a representative of another insurer);

(5) One (1) representative of an insurer other than a medical hospital service association plan selected by the commissioner;

(6) One (1) representative of the Tennessee Hospital Association selected by the commissioner;

(7) One (1) representative of the Tennessee Medical Association selected by the commissioner;

(8) One (1) insurance agent involved primarily in the sale of health insurance;

(9) One (1) member selected by the Governor;

(10) One (1) member selected by the Speaker of the Tennessee House of Representatives; and

(11) One (1) member selected by the Speaker of the Tennessee Senate.

(c) The commissioner and governor, in making the appointments to the board, shall strive to ensure that the membership of the board is representative of the state's geographic and demographic composition with appropriate attention to the representation of women and minorities.

(d) No individual representing an entity selected to administer the pool pursuant to § 56-7-2909 or its affiliates shall serve on the board.

(e) The commissioner shall, on an annual basis, designate one member of the board to serve as chair and one member of the board to serve as vice-chair.

(f) The board members selected pursuant to (b)(5) and (b)(9) shall serve for an original term of one (1) year. The board members selected pursuant to (b)(10) and (b)(11) shall serve for an original term of two (2) years. The board members selected pursuant to (b)(6), (b)(7) and (b)(8) shall serve for an original term of three (3) years. Thereafter, all board members selected pursuant to (b)(5) through (b)(11) shall serve for a term of three (3) years.

(g) Board members shall receive no compensation but shall be reimbursed for all travel expenses in accordance with state travel regulations.

(h) Vacancies in the board shall be filled by the commissioner. Board members may be removed by the commissioner for cause.

(i) The board, on an annual basis, shall submit to the commissioner and the comptroller of the treasury a funding plan and a plan for operation for the pool and any amendments thereto necessary or suitable to assure the fair, reasonable and efficient administration of the pool and its financial solvency based upon timely and accurate actuarial assumptions. The plan of operation shall become effective upon approval in writing by the commissioner and comptroller of the treasury.

(j) The commissioner and the comptroller of the treasury shall approve the funding plan and the plan of operation if they determine that the plans assure the financial solvency of the pool; the efficient administration of the pool, and otherwise are in compliance with the provisions of this part.

(k) If the board fails to submit a suitable plan of operation within one hundred eighty (180) days after the appointment of the board or at any time thereafter fails to submit suitable amendments to the plan of operation, the commissioner may initiate such actions as are necessary or advisable to effectuate the provisions of this part. Such actions shall continue in effect until modified by the commissioner or superseded by a plan of operation submitted by the board and approved by the commissioner and the comptroller. To the extent that such actions include the promulgation of rules to effectuate the provisions of this part, such rules shall be promulgated as public necessity rules pursuant to § 4-5-209.

(l) The plan of operation shall:

(1) Establish procedures for operation of the pool;

(2) Establish procedures for selecting an administrator in accordance with § 56-7-2909;

(3) Establish procedures to create a fund, under management of the board, for administrative expenses;

(4) Establish procedures for the handling, accounting, and auditing of assets, monies and claims of the pool and the pool administrator;

(5) Develop and implement a program to publicize the existence of the pool, the eligibility requirements, and procedures for enrollment, and to maintain public awareness of the pool;

(6) Establish procedures under which applicants and participants may have grievances reviewed by a grievance committee appointed by the board. The grievances shall be reported to the board after completion of the

review. The board shall retain all written complaints regarding the plan for at least three (3) years;

(7) Establish procedures to implement the requirements of § 56-7-2908(g); and

(8) Provide for other matters as may be necessary and proper for the execution of the board's powers, duties and obligations under this part.

(m) The funding plan shall:

(1) Establish premium rates for the upcoming year pursuant to § 56-7-2911(a);

(2) Establish an assessment rate for insurers and insurance arrangements pursuant to § 56-7-2911(b); and

(3) Identify other available funds for the pool including any legislative appropriations and federal funding.

(n) Board members are state officials and as such are absolutely immune from liability for acts or omissions within the scope of their duties as board members, except for willful, malicious or criminal acts or omissions done for personal gain.

56-7-2905. Access Tennessee has the general powers and authority granted under the laws of this state to insurance companies licensed to transact the kinds of insurance defined under § 56-2-201. In addition thereto, Access Tennessee has the specific power to:

(a) Enter into contracts as are necessary or proper to carry out the provisions and purposes of this part, including the authority, with the approval of the commissioner, to enter into contracts with similar pools of other states for the joint performance of common administrative functions, or with persons, other organizations or other state agencies for the performance of administrative functions;

(b) Sue or be sued, including taking any legal actions necessary or proper to:

(1) Avoid the payment of improper claims against the pool or the coverage provided by or through the pool;

(2) Recover any amounts erroneously or improperly paid by the pool;

(3) Recover any amounts paid by the pool as a result of mistake of fact or law; or

(4) Recover other amounts due the pool.

For purposes of this provision, as well as for legal representation of Access Tennessee, Access Tennessee is considered to be an instrumentality of the state for the purpose of being represented by the attorney general and reporter, pursuant to § 8-6-109;

(c) Establish, and modify from time to time as appropriate, rates, rate schedules, rate adjustments, expense allowances, claim reserve formulas and any other actuarial function appropriate to the operation of the pool. Rates shall be determined in relation to the coverage provided, the risk experience, and expenses of providing coverage. Rates and risk schedules may be adjusted for age, tobacco use and weight and shall take into consideration appropriate factors in accordance with established actuarial and underwriting practices;

(d) Establish a program to provide premium assistance to low income individuals eligible to participate in the pool;

(e) Issue policies of insurance in accordance with the requirements of this part;

(f) Appoint appropriate legal, actuarial and other committees as necessary, including advisory committees of external experts, to provide technical assistance in the operation of the pool, policy and other contract design and assistance with any other function within the authority of Access Tennessee;

(g) Request an annual audit by the comptroller of the treasury as otherwise provided by law or, with the prior written approval of the comptroller of the treasury, contract with an independent public accountant for the audit;

(h) Determine the eligibility requirements for pool participants and their dependents in accordance with the provisions of this part;

(i) Establish at least two coverage options pursuant to § 56-7-2910;

(j) Employ and set the compensation of or contract with any persons or entities necessary to assist Access Tennessee in carrying out its responsibilities and functions;

(k) Provide for reinsurance of risks incurred by the pool;

(l) Issue additional types of health insurance policies to provide optional coverage;

(m) Provide for and employ cost containment measures and requirements including, but not limited to, preadmission screening, second surgical opinion, concurrent utilization review, disease management and individual case management for the purpose of making the pool more cost effective;

(n) Design, utilize, contract or otherwise arrange for the delivery of cost effective health care services, including establishing or contracting with preferred provider organizations, health maintenance organizations and other limited network provider arrangements; and

(o) Adopt bylaws, policies, procedures and a plan document detailing pool benefits as may be necessary or convenient for the implementation of this part and the operation of the pool.

56-7-2906. Beginning by October 1, 2008, Access Tennessee shall make an annual report to the governor and comptroller of the treasury, to be submitted by October 1st of each year. The report shall be in a form approved by the commissioner and shall summarize the activities of Access Tennessee in the preceding calendar year, including the net written and earned premiums, enrollment, the expense of administration, and the paid and incurred losses. The report shall also include an evaluation of the ability of low income individuals to participate in the pool.

56-7-2907. The commissioner may, by rule, establish additional powers and duties of Access Tennessee and may adopt such rules as are necessary and proper to implement this part. Such rules shall be promulgated as public necessity rules pursuant to § 4-5-209. Such rules shall be promulgated in accordance with the Uniform Administrative Procedures Act compiled in title 4, chapter 5.

56-7-2908.

(a) A federally defined eligible individual who has not experienced a significant break in coverage and who is and continues to be a resident shall be eligible for pool coverage.

(b) The board may establish eligibility criteria to provide pool coverage for additional individuals.

(1) In the first twelve (12) months of the pool's operation, such criteria shall include, with respect to individuals who are not federally defined eligible individuals:

(A) A requirement that an individual be a resident of Tennessee for at least six (6) months;

(B) A requirement that an individual not have had health insurance coverage in the previous six (6) months;

(C) A requirement that an individual not have access to health insurance coverage at the time of application to the pool;

(D) A requirement that an individual exhaust any option of continuation coverage under a group or individual health insurance plan, including COBRA continuation coverage; and

(E) A requirement that the person not have coverage pursuant to § 56-7-2809.

The board shall establish procedures to verify that the criteria in subdivisions (A) through (E) have been met.

(2) In the first twelve (12) months of the pool's operation, Access Tennessee shall not offer coverage through the pool to dependents or other family members of a person who is eligible for pool coverage, unless such dependent or family member independently meets the eligibility criteria established by the board.

(3) At the end of the first year of the pool's operation or anytime thereafter the board may assess the implementation and impact of the eligibility criteria

established in subdivisions (b)(1) and (b)(2) and modify such criteria as it deems appropriate.

(4) The board may establish additional eligibility criteria to provide pool coverage for individuals who are not federally defined eligible individuals. Such criteria may include:

(A) A list of medical or health conditions for which a person shall be eligible for pool coverage without applying for health insurance;

(B) A requirement that an individual be uninsured for a specified period of time prior to obtaining pool coverage;

(C) Minimum residency requirements;

(D) Citizenship requirements; or

(E) Any other eligibility criteria that the board deems appropriate that are not in conflict with other provisions of this part.

(c) The board may establish limits on the number of individuals covered by the pool or the duration of pool coverage, based on available funding. In determining whether to adopt such limits, the board shall consider the amount of assessments required pursuant to § 56-7-2911(b), and shall attempt to keep such assessments at a reasonable level through the adoption of such limits if necessary.

(d) A person shall not be eligible for coverage through the pool if:

(1) The person has or obtains health insurance coverage substantially similar to or more comprehensive than a pool policy, or would be eligible to have coverage if the person elected to obtain it, except that:

(A) A person may maintain other coverage, including COBRA continuation coverage, for the period of time the person is satisfying any preexisting coverage waiting period under a pool policy; and

(B) A person may maintain pool coverage for the period of time the person is satisfying a preexisting condition waiting period under

another health insurance policy intended to replace the pool policy;

(2) The person is determined to be eligible for health benefits under Medicaid;

(3) The person has previously terminated coverage in the pool within twelve (12) months of the date that application is made to the pool, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual;

(4) The pool has paid out one million dollars ($1,000,000) in benefits on behalf of the person;

(5) The person is an inmate or resident of a public institution, except that this subdivision shall not apply with respect to an applicant who is a federally defined eligible individual;

(6) The person's premiums are paid for or reimbursed under any government sponsored program or by any government agency or health care provider, except as an otherwise qualifying full-time employee, or dependent thereof, of a government agency or health care provider; or

(7) The person has had prior coverage with the pool terminated for fraud.

The board may establish additional criteria that shall disqualify individuals for pool coverage, provided that such criteria do not apply to federally defined eligible individuals.

(e) Pool coverage shall cease:

(1) On the date a person is no longer a resident of Tennessee;

(2) On the date a person requests coverage to end;

(3) Upon the death of the covered person;

(4) On the date state law requires cancellation of the policy;

(5) At the option of the board, thirty (30) days after the pool makes any inquiry concerning the person's eligibility or place of residence to which the person does not reply; or

(6) At the option of the board, on a specified number of days after the day on which a premium payment for pool coverage becomes due if the payment is not made on or before that date.

(f) Except under the circumstances described in subsection (e), a person who ceases to meet the eligibility requirements of this section may be terminated at the end of the policy period for which the necessary premiums have been paid. Access Tennessee has the sole discretion to determine that a person does not meet the eligibility requirements.

(g) It shall constitute an unfair practice in the business of insurance for the purposes of § 56-8-104 and § 56-6-155 for an insurer, insurance producer or third-party administrator to refer an individual to the pool, or arrange for an individual to apply to the pool, for the purpose of separating that individual from group health insurance coverage. The board has the authority and responsibility to adopt policies and procedures that effectively implement this provision. The commissioner may impose a higher assessment pursuant to § 56-7-2911(b) on any entity determined, after appropriate notice and an opportunity for a hearing, to have violated this provision.

56-7-2909.

(a) The board shall provide for administration of the pool by electing in its plan of operation to have the pool administered:

(1) By the commissioner through the division of insurance administration;

(2) By using a competitive procurement process to select one (1) or more insurers or third party administrators to administer the pool; or

(3) Through a combination of both.

(b) If the board elects to use a competitive procurement process to select an insurer or administrator, the board shall evaluate proposals submitted based on criteria established by the board which shall include but need not be limited to:

(1) The insurer’s or administrator's demonstrated ability to handle health insurance coverage for individuals;

(2) The efficiency and timeliness of the insurer’s or administrator's claim processing procedures;

(3) The fees proposed to discharge the insurer’s or administrator’s responsibility;

(4) The insurer’s or administrator's ability to apply effective cost containment programs and procedures and to administer the pool in a cost-efficient manner;

(5) The insurer’s or administrator’s ability to implement effective disease and/or case management programs;

(6) The availability of a statewide network of providers for the pool; and

(7) The financial condition and stability of the insurer or administrator.

(c) A contracted insurer or administrator shall serve for a period specified in the contract between Access Tennessee and the selected insurer or administrator, subject to removal for cause and subject to any terms, conditions, and limitations of the contract.

(d) At least one (1) year prior to the expiration of each period of service by a selected insurer or administrator, the board shall invite eligible entities, including the current insurer or administrator, to submit proposals to serve for the succeeding period. Selection of the succeeding insurer or administrator shall be made at least three (3) months prior to the end of the current period.

(e) An insurer or administrator shall perform such functions relating to the pool as may be assigned to it, including:

(1) Determination of eligibility and collection of information regarding unfair referrals;

(2) Payment of claims based on rates established by the insurer or administrator;

(3) Establishment of a premium billing procedure for collection of premiums from persons covered under the pool;

(4) Making available information relating to the proper manner of submitting a claim for payments by the pool and distribution forms upon which submission shall be made; and

(5) Performance of other functions necessary to assure timely payment of benefits to persons covered under the pool.

(f) An insurer or administrator shall submit regular reports to Access Tennessee as required by the board regarding the operation of the pool. The frequency, content, and form of the report shall be specified in the contract between Access Tennessee and the insurer or administrator.

(g) Following the close of each calendar year, the insurer or administrator shall determine net written and earned premiums, other state or federal funding received by the pool, the expense of administration, and the paid and incurred losses for the year taking into account investment income and other appropriate gains and losses. The administrator shall report this information to the board, the department and the comptroller of the treasury on a form prescribed by the commissioner.

(h) A contracted insurer or administrator shall be paid as provided in the contract between Access Tennessee and the contractor.

56-7-2910.

(a) The pool shall offer at least two coverage options to each eligible person who is not covered by Medicare. One coverage option shall be modeled after one of the healthcare options offered to state employees pursuant to § 8-27-201 and one option shall combine a health savings account with a high deductible health plan. The board may adopt other coverage options as appropriate.

(b) The board, with the approval of the commissioner, shall establish:

(1) The coverage to be provided by each option;

(2) The applicable schedule of benefits; and

(3) Any exclusions to coverage and other limitations.

(c) In doing so, the board shall take into consideration the levels of health insurance coverage provided in the state and medical economic factors as may be deemed appropriate and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions, and limitations determined to be generally reflective of and commensurate with health insurance coverage provided through a representative number of large employers in Tennessee.

(d) The coverage options offered by the pool shall not be required to provide the mandated coverage or the mandated offers of coverage required pursuant to parts 23, 24, 25 or 26 of this chapter, unless required by the board.

(e) Pool coverage may exclude charges or expenses incurred during a period of time not to exceed twelve (12) months following the effective date of coverage as to any condition which, during a period not to exceed six (6) months immediately preceding the effective date of coverage, had manifested itself in such a manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or for which medical advice, care or treatment was recommended or received as to such condition. Any such preexisting condition exclusion shall be waived to the extent to which similar exclusions, if any, have been satisfied under any prior health insurance coverage which was involuntarily terminated, if the application for pool coverage is made not later than sixty (60) days following such involuntary termination and, in such case, coverage in the pool shall be effective from the date on which such prior coverage was terminated. No such exclusions may be applied to a federally defined eligible individual.

(f) The pool shall be payer of last resort of benefits whenever any other benefit or source of third-party payment is available. Benefits otherwise payable under pool coverage shall be reduced by all amounts paid or payable through any other health insurance coverage and by all hospital and medical expense benefits paid

or payable under any workers' compensation coverage, automobile medical payment or liability insurance whether provided on the basis of fault or nonfault, and by any hospital or medical benefits paid or payable under or provided pursuant to any state or federal law or program.

(g) Access Tennessee shall have a cause of action against an eligible person for the recovery of the amount of benefits paid that are not for covered expenses. Benefits due from the pool may be reduced or refused as a set-off against any amount recoverable under this subdivision.

(h) Nothing in this part shall be construed to prohibit Access Tennessee from issuing additional types of health insurance policies with different types of benefits which, in the opinion of the board, may be of benefit to those individuals otherwise eligible for coverage.

56-7-2911. The pool shall be funded in the manner set forth in this section.

(a) Premiums.

(1) The board shall establish premium rates for pool coverage as provided in subdivision (2). Separate schedules of premium rates based on age, tobacco use and weight may apply for individual risks. Premium rates and schedules shall be submitted to the commissioner for approval prior to use.

(2) The board, with the assistance of the commissioner, shall determine a standard risk rate by considering the premium rates charged by other insurers offering health insurance coverage to individuals. The standard risk rate shall be established using reasonable actuarial techniques, and shall reflect anticipated experience and expenses for such coverage. Initial rates for pool coverage shall not be less than 150% of rates established as applicable for individual standard risks. Subject to the limits provided in this subdivision, subsequent rates shall be established to provide fully for the expected costs of claims, including recovery of prior losses, expenses of operation, investment income of claim reserves, and any other cost factors subject to the limitations

described herein. In no event shall pool rates exceed two hundred percent (200%) of rates applicable to individual standard risks.

(3) Following the close of each fiscal year, the commissioner shall prepare a report analyzing the pool's projected revenues and expenditures and funding requirements. The commissioner shall present this report, together with the board's comments, to the Governor with a recommendation for the funding of the pool.

(b) Sources of Additional Revenue.

(1) The deficit incurred by the pool, reported by the insurer or administrator pursuant to § 56-7-2909(g), shall be funded through an assessment on insurers, insurance arrangements and third party administrators.

(2) The board is authorized to determine the amount and allocation of any assessments and advance interim assessments on insurers, insurance arrangements and third party administrators in accordance with the provisions of this section and subject to approval by the commissioner. The commissioner shall have the authority to assess insurers, insurance arrangements and third party administrators, and to make advance interim assessments as may be reasonable and necessary for the pool's organizational and interim operating expenses. Any such interim assessments are to be credited as offsets against any regular assessments due following the close of the fiscal year.

(3) The assessment for each individual insurer, insurance arrangement and third party administrator shall be determined by multiplying the total assessment of all insurers, insurance arrangements and third party administrators as determined in subdivision (2) by a fraction, the numerator of which equals the number of individuals in Tennessee covered by each individual insurer, insurance arrangement and third party administrator, and the denominator of which equals the total number of all individuals in

Tennessee covered by insurers, insurance arrangements and third party administrators, all determined as of the end of the prior calendar year.

(4) The board shall make reasonable efforts designed to ensure that each individual covered by insurers, insurance arrangements and third party administrators is counted only once with respect to any assessment. For that purpose, the board shall:

(i) Require each insurer and insurance arrangement that obtains excess or stop loss insurance to include in its count of insured individuals all individuals whose coverage is reinsured (including by way of excess or stop loss coverage) in whole or part;

(ii) Require each insurer and insurance arrangement that contracts with a third party administrator to include in its count of insured individuals all individuals whose coverage is administered in whole or part by a third party administrator;

(iii) Require each insurer that is an excess or stop loss insurer to include in its count of insured individuals all individuals covered through an insurance arrangement;

(iv) Require each third party administrator to include in its count of insured individuals all individuals covered through an insurance arrangement;

(v) Permit an insurer who is an excess or stop loss insurer to exclude from its number of insured individuals those who have been counted by the primary insurer or by the primary reinsurer or primary excess or stop loss insurer for the purpose of determining its assessment under this subsection;

(vi) Permit a third party administrator to exclude from its number of insured individuals those who have been counted by an insurer; and

(vii) Permit an insurance arrangement to exclude from its number of insured individuals those who have been counted by an excess or stop loss insurer or third party administrator.

(5) The amount of the assessment of each insurer, insurance arrangement or third party administrator shall be determined by the board based on annual statements and other reports deemed to be necessary by the board and filed by the participating insurer with the board or through other reporting mechanisms established by the department of commerce and insurance. The board may use any reasonable method of estimating the number of individuals covered by an insurer or insurance arrangement if the specific number is unknown. With respect to insurers that are reinsurers or excess or stop loss insurers, the board may use any reasonable method of estimating the number of persons insured by each reinsurer or excess or stop loss insurer. The commissioner shall approve and may make modifications to the board's determination of amounts and allocations of the assessments, and shall have the authority to issue and collect the assessments.

(6) An insurer, insurance arrangement or third party administrator may petition the commissioner for an abatement or deferment of all or part of an assessment imposed pursuant to this section. The commissioner may abate or defer, in whole or in part, the assessment if, in the opinion of the commissioner, payments of the assessment would endanger the ability of the insurer, insurance arrangement or third party administrator to fulfill its contractual obligations. In the event an assessment against an insurer,

insurance arrangement or third party administrator is abated or deferred in whole or in part, the amount by which the assessment is abated or deferred may be assessed against the other insurers, insurance arrangements and third party administrators in a manner consistent with the basis for assessments set forth in this subsection. The insurer, insurance arrangement or third party administrator receiving such abatement or deferment shall remain liable to the pool for the deficiency for four (4) years.

(c) The board shall operate the pool in a manner so that the estimated cost of providing health insurance coverage during any fiscal year will not exceed total income the pool expects to receive from policy premiums, assessments, funds appropriated by the state legislature, and monies received under the provisions of subsection (d). After determining the amount of funds appropriated to it for a fiscal year, the board shall estimate the number of new policies it believes the pool has the financial capacity to insure during that year so that costs do not exceed income. The board shall take steps necessary to assure that pool enrollment does not exceed the number of residents it has estimated it has the financial capacity to insure.

(d) The board shall make application for any federal grants or other federal sources under which the pool may be eligible to receive monies.

(e) Pool Fund.

(1) The Access Tennessee Health Insurance Pool fund shall be established as a separate account in the state treasury.

(2) Moneys in the fund, including interest earned on such moneys, shall be invested by the state treasurer, pursuant to §§ 9-4-602 and 9-4-603 for the sole benefit of the fund.

(3) Any moneys remaining in the fund at the end of the fiscal year shall not revert to the general fund, but shall be brought forward to the next fiscal year for the exclusive benefit of the fund's payment of future expenses.

56-7-2912 The office of inspector general, created pursuant to § 71-5-2502, shall have the authority to investigate civil and criminal fraud and abuse of Access Tennessee, or any other violations of state criminal law related to the operation of the pool. The powers of the office of inspector general set forth in §§ 71-5-2501 through 72-5-2512 relating to the investigation of fraud and abuse in the TennCare program shall also be applicable to its investigation of fraud and abuse of Access Tennessee.

SECTION 4. The department is authorized to provide health care coverage for pregnant women pursuant to SECTION 6, the CoverKids Act of 2006. The department may provide such coverage for pregnant women consistent with the provisions of such Act, except that no age-related eligibility restrictions shall apply to pregnant women.

SECTION 5. Tennessee Code Annotated, Title 56, Chapter 7 is amended by adding the following as a new part 29.

56-7-2901. This part shall be known and may be cited as the "Cover Tennessee Act of 2006."

56-7-2902. The purpose of this part is to expand health benefits coverage in Tennessee through a public-private partnership among employers, employees, uninsured individuals and the state. It is the intent of the general assembly to encourage employers to offer and employees and other individuals to obtain health care coverage by making such coverage available at affordable prices.

56-7-2903. As used in this part, unless the context otherwise requires:

(1) "Advisory committee" means the committee established pursuant to § 56-7-2905;

(2) "Commissioner" means the commissioner of finance and administration;

(3) “Contractor” means a health insurance carrier or third party administrator that enters into a contract with the department pursuant to § 56-7-2908 to offer a plan to eligible individuals;

(4) “Contributing employer” means an employer that has, pursuant to § 56-7-2914, elected to contribute towards the premiums of one or more of its employees who have enrolled in the program;

(5) “Department” means the department of finance and administration;

(6) “Dependent” means a dependent of an eligible individual, as defined by the department;

(7) “Eligible individual” means an individual who meets the eligibility criteria established by the department pursuant to § 56-7-2906;

(8) “Enrollee” means an eligible individual or a dependent who is enrolled in a plan;

(9) “Health insurance carrier” means an entity that is authorized to provide health insurance coverage in Tennessee in accordance with this title, including but not limited to an insurance company, a health maintenance organization, a non-profit hospital and medical service corporation, and a preferred provider organization;

(10) “Low income employee” means an employee whose income, as defined by the department, is less than 250 percent of the federal poverty level, or other such amount as the department may specify;

(11) “Participating small employer” means an employer with a small number of employees, a significant proportion of whom are low income employees, that meets the eligibility criteria established pursuant to § 56-7-2907(a);

(12) “Plan” means the health benefits coverage offered by a contractor to eligible individuals;

(13) “Program” means the Cover Tennessee program established pursuant to this part; and

(14) “Third party administrator” means an entity that, on behalf of a health insurance carrier, employer or other entity, provides health insurance coverage to individuals in this state, receives or collects charges, contributions or premiums for or adjudicates, processes or settles claims in connection with any type of health benefit provided in or as an alternative to health insurance coverage.

56-7-2904. The department is authorized to establish the Cover Tennessee program to offer health benefits coverage to eligible individuals through contractors.

56-7-2905. The commissioner is authorized to appoint an advisory committee to provide advice and assistance in implementing the program.

56-7-2906.

(a) The department shall establish eligibility criteria and guidelines for individuals to enroll in the program. Such criteria may include:

(1) Income and/or asset criteria;

(2) Residency requirements;

(3) Citizenship requirements;

(4) Insurance status;

(5) Employment status, including minimum number of hours per week and/or weeks per year worked; and

(6) Any other eligibility criteria deemed appropriate by the department and not in conflict with the provisions of this part.

(b) For the first year of operation of the program, the department shall require individuals to have been without health benefits coverage for six months prior to application in order to be eligible. Thereafter the department shall evaluate the impact of the program on the provision of other, employer-based coverage and may modify or eliminate this requirement pursuant to such evaluation.

(c) To the extent that all but a very limited number of a contributing employer's employees meet the eligibility criteria established pursuant to subsection (a), the department may elect to waive some or all of the eligibility criteria for those employees who do not meet the criteria.

(d) The department may limit the overall number of individuals enrolled in the program or the number of individuals in department-defined subcategories enrolled in the program.

(e) The department shall establish an application process for individuals to enroll in the program, and shall reevaluate the eligibility of such individuals on a periodic basis.

56-7-2907.

(a) The department shall establish eligibility criteria and guidelines for employers to qualify as participating small employers. Such criteria may include:

(1) Maximum number of employees;

(2) Location requirements;

(3) Percentage of employees that are low-income employees; and

(4) Any other eligibility criteria deemed appropriate by the department and not in conflict with the provisions of this part.

(b) For the first year of operation of the program, only employers who have not offered health benefits coverage to their low income employees for the previous six months shall be eligible to participate in the program. Thereafter, the department may modify or eliminate this requirement as appropriate.

(c) The department may, in its discretion, permit all of a participating small employer's employees to elect coverage through the program without regard to one or more of the eligibility criteria established by the department pursuant to § 56-7-2906(a).

(d) The department may require that a participating small employer contribute toward the premiums of its eligible employees on a uniform basis.

(e) The department may limit the number of participating small employers who are authorized to participate in the program.

(f) The department shall establish an application process for small employers seeking to participate in the program and shall reevaluate the eligibility of such employers on a periodic basis.

(g) Participating small employers shall make premium contributions for each enrolled employee consistent with § 56-7-2914.

(h) The department may determine whether participating small employers must offer their employees a choice among all of the plans available through the program or may specify which plan or plans are offered to their employees.

56-7-2908

(a) The department may enter into contracts with one or more health insurance carriers or third party administrators selected through a competitive procurement process to provide a plan of health benefits coverage to eligible individuals. In soliciting proposals to provide such coverage, the department may:

(1) Specify rates to be paid by the program to the contractor;

(2) Specify minimum requirements with respect to the health benefits to be covered by the plan, which shall prioritize preventative health services. The department shall consider requiring the plan to cover generic prescription drugs and routine physician visits with only limited cost sharing. The department may permit limitations on the amount of such services covered by the plan, and may permit increased cost sharing at higher utilization levels. The department shall not permit a plan to subject such services to a large global deductible;

(3) Solicit proposals with respect to specific benefits to be covered by the plan, including any limits on such benefits, provided that the department encourages as broad a benefit package as possible for the rates provided, with benefit limits or higher cost-sharing for appropriate services (such as non-preventative services) preferred over exclusions as a mechanism for controlling costs;

(4) Provide other incentives for the development of benefit packages emphasizing preventative and primary care coverage;

(5) Specify requirements and/or solicit proposals with respect to plan coverage of dependents of eligible individuals (including separate rates for dependent coverage or a requirement or proposal that no dependent coverage be offered);

(6) Specify requirements and/or solicit proposals with respect to plan coverage of maternity services (including separate rates for such coverage);

(7) Specify requirements and/or solicit proposals with respect to plan coverage or exclusions of pre-existing conditions; provided that no pre-existing condition provision subjects an enrollee to an exclusion of longer than twelve (12) months;

(8) Specify requirements and/or solicit proposals with respect to enrollee cost-sharing, including cost-sharing based on a sliding scale in accordance with income as appropriate;

(9) Specify requirements and/or solicit proposals with respect to provider networks, consistent with the prioritization of primary care services. Where geographically appropriate, the department should encourage selective contracting with high performance provider networks meeting specified quality, cost and patient satisfaction criteria, and should encourage pay-for-performance provider rate structures

designed to reward quality of care and cost-effective medicine, where appropriate;

(10) Specify requirements and/or solicit proposals with respect to quality assurance, quality improvement, disease prevention, disease and/or case management, cost-containment, provider reimbursement mechanisms, the use of health information technology, wellness programs, incentives for healthy living and any other programmatic innovations or requirements. The department should encourage plans to promote enrollee wellness and personal responsibility (such as mandatory twelve- (12-) month waiting periods for enrollees who have previously dropped coverage) and to establish “equity” programs in which enrollees can earn reduced cost-sharing and/or increased benefits through appropriate behavior (such as extended participation in the plan or participation in disease management or other designated programs offered by the plan);

(11) Specify requirements and/or solicit proposals with respect to application and enrollment processes;

(12) Specify requirements and/or solicit proposals with respect to procedures for the plan to collect premium contributions required pursuant to § 56-7-2914;

(13) Specify requirements and/or solicit proposals with respect to continuing coverage for enrollees who leave the employment of a contributing employer;

(14) Specify any applicable marketing guidelines, requirements and/or restrictions, including the use of the existing commercial brokerage network or other more direct distribution mechanisms where appropriate;

(15) Specify any applicable reporting requirements for contractors; and

(16) Include any other specifications or incentives as the department deems appropriate.

(b) Notwithstanding the requirements of § 12-4-109, the department may:

(1) Consult with experts from outside the department and outside of state government in evaluating proposals to provide coverage under the program; and

(2) Consider the factors specified in its solicitation of proposals in awarding contracts.

(c) The department shall seek to offer at least two (2) plans to eligible individuals, and shall enter into contracts with one or more contractors to provide such plans. The contract shall set forth the department's agreements with such contractor with respect to the items contained in subsections (a)(1) through (a)(16), to the extent applicable, and any other necessary terms and conditions.

(d) Contractors shall be permitted to design the health benefits coverage offered through such plans consistent with the requirements of this part and with any additional requirements established by the department.

(e) Contractors may subcontract for the provision of medical, administrative or other services in connection with the plan.

(f) The department shall compensate contractors as provided in the contract. The department may offer incentives including a bonus payment to the contractor(s) that meets enrollment criteria specified by the department, or for meeting other performance criteria specified by the department.

56-7-2909. The department shall require each contractor to accept for enrollment in the plan every eligible individual and eligible dependent (to the extent dependent coverage is offered) who applies for coverage without regard to any medical conditions. This section shall not preclude the department from permitting plans to exclude coverage for preexisting conditions in accordance with criteria established by the department pursuant to § 56-7-2908.

56-7-2910. Contractors shall permit enrollees to remain enrolled in a plan following a change in employment or loss of employment, provided that:

(a) The enrollee continues to meet the eligibility criteria specified in § 56-7-2906 with the exception of employment criteria;

(b) The enrollee continues to contribute the required premium amounts pursuant to § 56-7-2914; and

(c) If the enrollee is employed but not by a contributing employer, the enrollee contributes the premium amount specified pursuant to § 56-7-2914(a)(4).

The department may specify the length of time and other conditions under which an enrollee who is unemployed may remain enrolled in a plan pursuant to this section.

56-7-2911.

(a) Contractors shall ensure that health care providers providing services to plan enrollees:

(i) Do not charge enrollees or third parties for health care services covered by the plan in excess of the amount allowed by the plan, except for any applicable co-payments, deductibles or coinsurance;

(ii) Do not refuse to provide services to a plan enrollee on the basis of health status, medical condition, previous insurance status, race, color, creed, age, national origin, gender, sexual orientation, disability or marital status. This subparagraph may not be construed to require a provider to furnish medical services that are not within the scope of that provider's license; and

(iii) Are reimbursed at the negotiated reimbursement rates between the contractor and its provider network.

(b) Health care providers shall not be required to provide services to enrollees who refuse or fail to meet their cost sharing responsibilities.

(c) Contractors shall ensure that the state (through the department) and the enrollees benefit financially from any contracts maintained between the contractor and health care providers providing services to plan enrollees. All special pricing considerations, financial incentives and discounts incorporated into such contracts shall accrue to the state and the enrollees.

56-7-2912. It is the intent of the General Assembly that plans offered through the program shall not be required to provide the mandated coverage or the mandated offers of coverage required pursuant to parts 23, 24, 25 or 26 of this chapter, including any similar mandates that may be added in the future to this or any other chapter, except as required by the department.

56-7-2913. Plans offered through the program shall be exempt from the taxes imposed by § 56-4-205.

56-7-2914.

(a) On an annual basis, based on contracts entered into with contractors, the department shall determine the premiums for each plan offered through the program, including premiums for coverage for dependents, and shall specify:

(1) The amount or percentage of such premium to be contributed by the state through the department, subject to an appropriation for this purpose;

(2) The minimum amount or percentage of such premium to be contributed by the contributing employer or the participating small employer;

(3) The maximum amount or percentage of such premium to be contributed by enrolled individuals who are employees of a contributing employer or a participating small employer; and

(4) The amount or percentage of such premium to be contributed by enrolled individuals who are not employees of a contributing employer or a participating small employer.

(b) The department may reduce or eliminate the premiums required by subsection (a)(1) and may adjust the premium contributions required by subsections (a)(2) and (3) for employees receiving coverage solely pursuant to § 56-7-2906(c) or § 56-7-2907(c).

(c) Based on available appropriations, the department may limit the number of enrollees for whom the state will provide a premium contribution pursuant to subsection (a)(1), may establish eligibility criteria to qualify for premium contributions by the state and/or may reduce the amount of premium contributions by the state for some or all contributing employers. To the extent that the state does not contribute to the premium of an enrollee or contributes a reduced amount, the employer, employee and/or individual contributions required pursuant to subsections (a)(2) through (a)(4) shall be adjusted accordingly.

(d) The department may establish separate premium contribution levels for the state, employers, employees and individuals with respect to dependent coverage.

(e) Contributing employers or participating small employers may establish the amount of the required employer and employee premium contributions for their employees provided that the employer contribution is not less than the amount specified by the department pursuant to (a)(2) of this section and the employee contribution is not more than the amount specified by the department pursuant to (a)(3) of this section. The sum of the employer and employee premium contributions must equal the sum of the amounts specified by the department pursuant to (a)(2) and (a)(3).

(f) During the first three (3) years of operation of the program, premium amounts charged to employers, employees and individuals pursuant to this section shall not increase more than ten percent (10%) per year.

(g) To the extent possible, the department shall ensure that premium schedules and required premium contributions are as simple and affordable as is feasible.

(h) The department may establish premium schedules based on age, tobacco use or obesity.

(i) The department may either:

(1) Establish a method to collect premium contributions from contributing employers, participating small employers and enrollees and pass such contributions, along with the state's contributions, to the plan; or

(2) Authorize contractors to collect premium contributions from contributing employers, participating small employers and enrollees.

56-7-2915. The department may enter into contracts or interagency agreements with outside entities or other state agencies to assist in the administration of the program.

56-7-2916. The department shall, to the extent feasible, ensure that the application processes for this program are simplified and are coordinated with other health benefits coverage programs offered by the state. The department shall seek to direct individuals into the health benefits coverage program that offers the most appropriate coverage for the individual, taking into account the individual's unique circumstances.

56-7-2917. The department may contract with an outside entity to conduct an evaluation or evaluations of the program.

56-7-2918. The department may establish periodic reporting requirements and audit requirements for contractors. Contractors shall maintain complete and detailed records as specified by the department regarding the operation of the plan, and shall provide the department and the Comptroller's office with access to such records under the terms defined by the department.

56-7-2919. Any moneys remaining in the program at the end of the fiscal year shall not revert to the general fund, but shall be brought forward to the next fiscal year for the exclusive benefit of the program.

56-7-2920. The program shall not constitute an entitlement to coverage for eligible individuals, and the availability of program benefits are subject to appropriations. Nothing established or supported pursuant to the provisions of this part shall in any way be constructed or determined to be an entitlement by any individual or entity to any coverage or benefits established by this program or to any medical assistance, medical services, or any pharmacy services or, if such assistance or services are provided, to any continuing assistance or services by the state or by any other entity or person.

56-7-2921. The commissioner is authorized to promulgate any rules necessary to carry out the proper administration of this part. Such rules shall be promulgated as public necessity rules pursuant to § 4-5-209. Such rules shall be promulgated in accordance with the provisions of the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

56-7-2922. The office of inspector general, created pursuant to § 71-5-2502, shall have the authority to investigate civil and criminal fraud and abuse of the program, or any other violations of state criminal law related to the operation of the program. The powers of the office of inspector general set forth in §§ 71-5-2501 through 72-5-2512 relating to the investigation of fraud and abuse in the TennCare program shall also be applicable to its investigation of fraud and abuse of Cover Tennessee.

SECTION 6. Tennessee Code Annotated, Title 71, Chapter 3, is amended by adding the following as a new part 11:

71-3-1101. This part shall be known and may be cited as the “CoverKids Act of 2006.”

71-3-1102. The purpose of this part is to create a program to provide health care coverage for uninsured children who are not eligible for health care services under any part of Tennessee’s Medicaid program, either pursuant to the Medicaid state plan or pursuant to any Medicaid waivers secured by the bureau of TennCare. It is the intent of the legislature to create and fund a program separate from the Tennessee Medicaid program and Title XIX, and not subject to any consent decrees or judicial orders applicable to the Tennessee Medicaid program.

71-3-1103. As used in this part, unless the context otherwise requires:

(1) “Department” means the department of finance and administration;

(2) “Enrollee” means an individual who is eligible and enrolled in the program;

(3) “Program” means any program established to provide health coverage to children pursuant to this part;

(4) “Tennessee Medicaid program” means the federal- and state-financed, state-run program of medical assistance established pursuant to Title XIX, including any waivers thereof;

(5) Title XIX means Title XIX of the Social Security Act, Subchapter XIX, Chapter 7 of Title 42, United States Code, providing grants to state for medical assistance programs; and

(6) “Title XXI” means Title XXI of the Social Security Act, Subchapter XXI, Chapter 7 of Title 42, United States Code, establishing the State Children’s Health Insurance Program.

71-3-1104. The department is authorized to establish, administer, and monitor a program to provide health care coverage to uninsured children pursuant to Title XXI. The department may not use money appropriated for this program to expand eligibility criteria for the Tennessee Medicaid program or any other program operated under this Title. The program shall not constitute an entitlement to coverage for eligible individuals, and the availability of program benefits are subject to appropriations.

71-3-1105. The department is authorized to seek federal approval for the program pursuant to Title XXI through a state plan, state plan amendment or request for federal waivers.

71-3-1106.

(a) The department shall adopt rules and regulations to establish eligibility criteria for the program which shall limit eligibility to an individual who:

(1) is 18 years of age or younger;

(2) has a combined family income at a level to be determined by the department;

(3) is not already covered by private insurance that offers creditable coverage, as defined in 42 U.S.C. 300gg(c);

(4) is not eligible for coverage under the Tennessee Medicaid program;

(5) is a United States citizen or qualified alien as defined in 8 U.S.C. 1641(b); and

(6) is a Tennessee resident.

(b) The department may establish such additional eligibility criteria as appropriate.

(c) The department may establish a cap on the number of individuals who may be enrolled in the program.

(d) The department may establish an option for individuals who do not meet eligibility criteria necessary to obtain Title XXI funding to purchase coverage through the program.

71-3-1107.

(a) The department may administer the program directly or contract with insurance companies, managed care plans or other entities to provide services to enrollees. Payments for services to such contracted entities may require the contractor to assume full or partial risk for the cost of services provided under the contract. The department may also contract directly with health care providers to provide services to enrollees and establish appropriate rates of payments for such services.

(b) The department may enter into contracts or interagency agreements with an outside entity or other state agency to assist in the administration of the program, including performing eligibility determinations and appeals.

71-3-1108.

(a) The department may adopt additional rules and regulations governing the program, including but not limited to any rules or regulations necessary to comply with or to implement the provisions of any federal requirement, federal waiver or state plan governing the program. The department is authorized to promulgate public necessity rules pursuant to Section 4-5-209. All rules and regulations governing the program shall be promulgated in accordance with the provisions of the Uniform Administrative Procedures Act, compiled in title 4, chapter 5.

(b) The rules may include, as necessary, but need not be limited to:

(1) the application, enrollment and disenrollment processes for the program;

(2) the benefit package to be provided through the program;

(3) provisions for participant cost sharing, if any, including, at the department's discretion:

(A) the establishment of enrollment fees, premiums, deductibles and co-payments; and

(B) the process for setting the amounts of enrollment fees, premiums, deductibles, and co-payments, taking into account a participant's family income;

(4) the type of professionals or other provider entities who may deliver services or direct the delivery of services and the qualifications required of those professionals or entities; and

(5) provisions regarding the sharing of health information under this plan.

(c) In adopting rules, the department shall consider the federal requirements on which the receipt of Title XXI funding is contingent and shall not establish any program criteria or requirements that will disqualify the program for such funding. Rules adopted by the department must, when appropriate, take into account the availability of appropriated funds.

SECTION 7. Tennessee Code Annotated, Section 71-5-2502, is amended by adding the following as a new, appropriately designated subsection:

( ) Investigate civil and criminal fraud and abuse, or any other violations of state criminal law, related to the operation of any program created pursuant to Section 3, the Access Tennessee Act of 2006; Section 5, the Cover Tennessee Act of 2006; and Section 6, the CoverKids Act of 2006.

SECTION 8. If any provision of this Act or the application thereof to any person or circumstance is held invalid, such invalidity shall not affect other provisions or applications of the Act which can be given effect without the invalid provision or application, and to that end the provisions of this Act are declared to be severable.

SECTION 9. This Act shall take effect upon becoming a law, the public welfare requiring it.